BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Ernest L. Bonner, Jr., M.D.	)	Case No. 12-2006-179491
Physician's and Surgeon's Certificate No. A30477	)	
Respondent	)	

DECISION

The attached Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on April 18, 2013.

IT IS SO ORDERED: March 19, 2013.

MEDICAL BOARD OF CALIFORNIA

Barbara Yaroslavsky, Chair
Panel A

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
ERNEST L. BONNER, JR., M.D.,	Case No. 12-2006-179491
Physician and Surgeon's Certificate No. A30477	OAH No. 2012090591
Respondent.	

PROPOSED DECISION

Administrative Law Judge Ruth S. Astle, State of California, Office of Administrative Hearings, heard this matter in Oakland, California on January 7, 8, and 9, 2013.

Jane Zack Simon and Lawrence Mercer, Deputy Attorneys General, represented complainant.

Respondent Ernest L. Bonner, Jr., M.D. was present and represented himself.

Submission of the matter was deferred to February 5, 2013, for written argument. Written argument was received from both parties, marked for the record and considered. The matter was submitted on February 5, 2013.

FACTUAL FINDINGS

1. Complainant Linda K. Whitney made the accusation in her official capacity as the Executive Director of the Medical Board of California (Board).

2. On September 27, 1976, Physician and Surgeon's Certificate No. A30477 was issued by the Board to Ernest L. Bonner, Jr., M.D. (respondent). Respondent's certificate is renewed and current and will expire on September 30, 2013.

Patient W.C.

3. Patient W.C., a 58 year-old male living in a board and care facility, came under respondent's care and treatment in May 1996. The patient had a past medical history

significant for a diagnosis of schizophrenia, anemia, and chronic obstructive pulmonary disease (COPD), among other serious medical conditions.

4. Respondent recommended a fecal occult blood test, but the patient was not willing to submit a stool sample. Respondent continued to be concerned about the patient's anemia. Respondent continued to order tests, which beginning on January 28, 2005, indicated a decreased hemoglobin level. On the next visit, March 2, 2005, respondent charted a plan for GI referral for a screening colonoscopy and this referral is repeated at the next visit and sporadically in later records. Respondent established that patient W.C. refused a colonoscopy. The patient's condition continued to deteriorate. Respondent ordered further testing, which was initially refused by the patient.

5. On January 2, 2009, the patient was losing weight. A laboratory test was performed on January 13, 2009 and reported on January 15, 2009, and reviewed by respondent on January 23, 2009, which showed the patient's hemoglobin level had dropped to 6.8 and required urgent hospitalization. Patient W.C. was admitted to the hospital for evaluation, at which time a right colonic mass was diagnosed using a Barium enema. Patient W.C. refused treatment at the hospital and was discharged back to his board and care facility. On April 13, 2009, the patient was readmitted to the hospital for weakness and a diagnosis of metastatic colon cancer was given. The patient again refused treatment, which was considered reasonable given his terminal diagnosis.

6. Respondent's medical records for this patient were duplicative and redundant, repeatedly indicating the same examinations and findings in a serial, unlikely fashion. It appears that respondent copied his records from one visit to another. He created a template with some basic information and copied that from visit to visit without regard to what actually occurred at each visit. He added some notes at each visit by interlineation. His medical records for this patient were inaccurate, inadequate, and impossible to understand. Material information was left out, including the patient's refusal to undergo a colonoscopy.

Beginning in March 2007, respondent adopted an electronic format for his medical record keeping. Beginning at that time, respondent produced a six-page record for each visit in which extensive, detailed physical examinations are indicated by checked boxes. The records are inaccurate and unreliable. They contain typographical errors that are repeated from visit to visit.

7. It was not established by clear and convincing evidence that respondent failed to recognize or follow up on signs and symptoms of colon cancer. On the contrary, respondent did what he could with a difficult, non-compliant patient.

Patient T.F.

8. Patient T.F., a 28 year-old male living in a board and care facility, came under respondent's care and treatment on October 28, 2003. The patient had a past medical history

significant for a diagnosis of Lowe's Syndrome, with severe mental retardation, seizure disorder, and renal tubular dysfunction, among other serious medical problems.

9. Respondent saw Patient T.F. approximately every 2 to 3 months until the patient was admitted to St. Rose Hospital for a kidney infection on June 25, 2009. Respondent's medical records are redundant and repetitive, without changes between multiple visits. It is difficult to determine from the medical records what exactly the condition was of the patient at any particular time. There is an error, repeated in the medical records, that the patient was on chronic anti-psychotic medication, when he was not. The medical indication on the records for the visits was not clear, since respondent listed the patient's long term medical problems as "complaints". However, it was reasonable to see this patient every 2 to 3 months to rule out any emerging medical conditions, since this patient was so impaired. The medical records are form records that are repeated from visit to visit, with some additions noted. For instance, the form indicates a psychiatric examination was repeated for multiple visits, when respondent intended to indicate that nothing had changed.

As stated above, in 2007, respondent adopted an electronic format for his medical records. There continued to be problems with the electronic records for this patient. The six-page record was copied from visit to visit with only a few specific notations. The records are incomplete, difficult to decipher and are missing material information concerning difficulty in referring this patient for his medical problems.

10. It was not established by clear and convincing evidence that respondent failed to order appropriate laboratory tests and consultations for evaluation and follow up of Patient T.F.'s multiple medical problems.

Patient H.C.

11. Patient H.C., a 65 year-old schizoaffective male residing in a board and care facility, was first seen by respondent on December 18, 2005. The patient had a past medical history, as documented by respondent, which was significant for schizoaffective disorder, COPD, and insomnia. The patient's chronic medication upon respondent's assumption of care were Ambien, clonazepam at night, Depakote, Lamictal, Neurontin, Risperdal, Zyprexa, and multivitamins. On the first examination, respondent did not perform a complete mental evaluation of this patient. Respondent's medical records did not indicate that this patient was under the care of a psychiatrist for his psychiatric diagnosis and his psychiatric medications. Respondent spoke regularly with the patient's psychiatrist and other mental health care professionals who had responsibility for this patient and never recorded it in his medical records. The records leave the impression that respondent is prescribing the psychiatric medications. The records also show multiple examinations copied from visit to the next without any changes to show what actually transpired at the visit. Respondent ordered multiple tests without documented rationale and referrals are made for tests like a colonoscopy, without apparent follow-up or documentation of the results.

12. It was not established by clear and convincing evidence that on July 29, 2008, respondent failed to follow-up when Patient H.C. was found to have an unexplained high potassium value. It fact it was a laboratory error. Respondent lost contact with this patient when the patient was transferred to another facility.

Patient W.M.

13. Patient W.M., a 60 year-old male living in a board and care facility, came under respondent's care and treatment on March 16, 2002. The patient had a past medical history, as documented by respondent, which was significant for schizoaffective disorder, COPD, GERD, dementia, history of alcoholism and hepatitis C. His medications in 2002 were Zyprexa, clonazepam, Ambien, Depakote, BuSpar, Benadryl, and Paxil. Respondent elected to continue W.M.'s present medications. The medical record is inadequate. It does not show who prescribed the psychiatric medications for the patient. Respondent was, in fact, not the physician who prescribed these medications.

14. Although Patient W.M. had a history of hepatitis C, respondent failed to document any follow up on significantly abnormal laboratory test results. On September 17, 2009, Patient W.M. was found to have an elevated AFP, which was highly significant given the patient's history of liver disease and might be indicative of something more serious like liver cancer. Respondent's notes for this patient discussed a possible CT scan of the abdomen and pelvis, but there is nothing in the records to show any follow up. Respondent testified that he did get the results of a CT scan, but admitted that he did not put that in his medical records.

Patient J.B.

15. Patient J.B., a 33 year-old developmentally disabled male residing in a board and care facility, was first seen by respondent on April 28, 2004. J.B. had a history of fecal incontinence since birth, as well as a seizure disorder (with his last seizure five years prior). The latter was being treated with Depakote and phenobarbital. When respondent took over J.B.'s care, his medications were phenobarbital, Neurontin, Seroquel, and Depakote.

16. Respondent continued to treat Patient J.B. through May 2009. Although the patient was taking multiple potent medications, respondent's records regularly omitted reference to a medical indication for the medical visit or information regarding the patient's response to the prescribed treatment. Multiple examinations are copied from visit to visit, while these detailed multi-system evaluations were not performed at each visit. Abnormal laboratory values are noted at various times, but then are not followed up in the records.

Patient C.C.

17. Patient C.C., a 40 year-old schizophrenic male, who also suffered from hypertension, hypercholesterolemia, and an anxiety disorder, resided at a board and care

facility and was first seen by respondent on September 12, 2004. Patient C.C.'s medications at the time were Toprol, Risperdal, carbamazepine, and clonazepam.

18. Respondent continued to treat Patient C.C. through January 2010. Although the patient was taking multiple potent medications, respondent's records regularly omitted reference to a medical indication for the medical visit or information regarding the patient's response to the prescribed treatment. Multiple examinations are copied from visit to visit, while these detailed multi-system evaluations were not in fact performed at each visit. Although respondent ordered laboratory tests on June 1, 2005, many subsequent records list the labs as "pending" without explaining why or what was being done to get the tests completed. On July 23, 2008, there is documentation that the laboratory tests were actually performed and the results received.

19. Complainant's expert, Smita Chandra, M.D., established by clear and convincing evidence that respondent's medical records for Patients W.C., T.F., H.C., W.M., J.B., and C.C. each constituted a simple departure from the standard of practice and taken together, constitute repeated negligent acts. The records were repetitive, inaccurate, contained nonsense, contained typographical errors, and did not contain all material facts necessary for a subsequent treating physician to understand the care and treatment for the patients by respondent.

20. However, it was not established by clear and convincing evidence that the actual care of the patients constituted a departure from the standard of care. Complainant's expert agreed with respondent that the population of patients that he cared for was particularly difficult. The patients did not comply with respondent's medical advice and did not always have the means to obtain the tests ordered by respondent.

21. Patricia Shepherd Payton runs a licensed board and care facility and an independent living facility in Oakland, California. She tried to get Patient W.C. to comply with respondent's testing recommendations, especially a colonoscopy, but the patient refused. She was happy with the care respondent gave her residents.

22. Vernette Suggs, a licensed administrator for a residential care facility licensed for mentally ill clients who were totally disabled, testified at the hearing that respondent sees the majority of the residents in her facility for the last 18 years. Respondent spends about 45 minutes with each client. Respondent first gets information from the staff and then sees each patient. Respondent is the most thorough physician she has encountered. He comes monthly for two days to see every resident. Respondent will also respondent to calls for acute care. She also verified that patients refuse to comply with tests and it sometimes takes coaxing from respondent and from herself to get residents to comply.

23. Harold Orr, M.D. testified at the hearing that he has known respondent since 1980. Respondent is a thorough physician with an excellent reputation with his colleagues. Dr. Orr and respondent have shared patients in the past. Dr. Orr's daughter was treated by respondent and Dr. Orr found respondent's treatment to have been appropriate.

24. Herbert Johnson, a past employee of respondent's testified at the hearing that he went to residential care facilities with respondent from 1991 to 2005. Mr. Johnson confirms that the patient population served by respondent was often non-verbal or had language difficulties. Respondent would spend from 30 minutes to two hours with a patient depending on the needs of the patient.

25. Ralph Peterson, M.D. also testified as a character witness on respondent's behalf. Dr. Peterson has an accusation pending by the Medical Board. He testified that respondent has a good reputation in the community.

26. Respondent developed his medical record practices in an attempt to comply with billing requirements for governmental and insurance agencies. They do not meet the standard of practice for the profession. Originally, he was investigated by a governmental payer for billing fraud (Department of Health Care Services), but was eventually exonerated. Respondent has not taken a record keeping class since this matter was brought to his attention.

27. The Board has expressed concern about respondent's medical knowledge. At the interview with the Board's District Medical Consultant, respondent answered some basic questions about vaccines for pneumonia and treatment for methicillin-resistant staph. aureus (MRSA) incorrectly. This is relevant to the disciplinary action that should be taken and the terms and conditions that should be included in respondent's probationary order.

28. Respondent graduated from Duke University School of Medicine with his M.D. degree in 1975. He completed a straight medicine residency at Martinez VA hospital (UC Davis service) in Martinez, California. He also completed a renal fellowship at the US Public Health Service Hospital in San Francisco, California, in 1980. Respondent is in private practice and does not have hospital privileges.

29. All motions and other matters have been considered. If it is not specifically addressed in this decision, these matters are found to be without merit and either not considered or dismissed.

LEGAL CONCLUSIONS

1. By reason of the matters set forth in Findings 3 through 6 (Patient W.C.), Findings 8 and 9 (Patient T.F.), Finding 11 (Patient H.C.), Findings 13 and 14 (Patient W.M.), Findings 15 and 16 (Patient J.B.), Findings 17 and 18 (Patient C.C.), and Finding 19, cause for disciplinary action exists pursuant to Business and Professions Code sections 2234, subdivision (c) (repeated negligent acts) and 2266 (failure to maintain adequate and accurate records).

2. By reason of the matters set forth in Findings 7 (Patient W.C.), 10 (Patient T.F.), 12 (Patient H.C.), and 20, cause for disciplinary action does not exist pursuant to

Business and Professions Code sections 2234 (unprofessional conduct), and/or 2261(false statement of facts).

3. The matters set forth in Findings 21 through 28 have been considered in making the following order. It would not be against the public interest and safety to allow respondent to continue to practice under terms and conditions of probation.

ORDER

Certificate No. A30477 issued to respondent Ernest L. Bonner, Jr., M.D. is revoked. However, revocation is stayed and respondent is placed on probation for three (3) years upon the following terms and conditions:

1. Monitoring - Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole

responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Board or designee.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

2. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

3. Medical Record Keeping Course

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first six months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. Ethics Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in ethics, at respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

An ethics course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the

scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Board or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

6. Notification

Prior to engaging in the practice of medicine the respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

8. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. Probation Unit Compliance

Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Board or its designee.

Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

11. Interview with the Board or its Designee

Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Board or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

12. Residing or Practicing Out-of-State

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051, and 2052, of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

Any respondent disciplined under Business and Professions Code sections 141(a) or 2305 (another state discipline) may petition for modification or termination of penalty: if at least one year has elapsed from the effective date of the California discipline.

13. Failure to Practice Medicine - California Resident

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051, and 2052, of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

14. Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

15. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Board shall have

continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Board reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

17. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

DATED: February 20, 2013

Ruth S. Astle

RUTH S. ASTLE
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **ERNEST L. BONNER, JR., M.D.** 2014 Santa Clara Avenue Alameda, CA 94501 Physician's and Surgeon's Certificate No. A30477, Respondent.	Case No. 12-2006-179491 **FIRST AMENDED ACCUSATION**

PARTIES

1. Linda K. Whitney (Complainant) brings this First Amended Accusation (Accusatoin) solely in her official capacity as the Executive Director of the Medical Board of California (Board) Department of Consumer Affairs.

2. On September 27, 1976, the Medical Board of California issued Physician's and Surgeon's Certificate Number A30477 to Ernest L. Bonner, Jr., M.D. (respondent.) Said certificate is renewed and current with an expiration date of September 30, 2013.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California[1] under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked or suspended for a period not to exceed one year; or the licensee may be placed on probation and may be required to pay the costs of probation monitoring or may have such other action taken in relation to discipline as the Division deems proper.

5. Section 2234 of the Code provides that the Medical Board shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes, but is not limited to:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter [Chapter 5, the Medical Practice Act].

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care. . ."

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[1] The term "Board" means the Medical Board of California. "Division of Medical Quality" shall also be deemed to refer to the Board.

6. Section 2261 of the Code provides that it is unprofessional conduct to make or sign any certificate or other document relating to practice of medicine which falsely represents the existence or non-existence of a state of facts.

7. Section 2266 of the Code provides that the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to his or her patients constitutes unprofessional conduct.

FIRST CAUSE FOR DISCIPLINARY ACTION

(Patient W.C.)

(Gross Negligence, Repeated Negligent Acts/False & Inadequate Records)

8. Respondent's license is subject to discipline and respondent is guilty of unprofessional conduct in violation of Business and Professions Code §§ 2234, and subsections (b) and/or (c), and/or §2261 and § 2266 in that respondent was grossly negligent and/or committed repeated negligent acts and/or failed to maintain truthful, adequate and accurate medical records in his patient care and treatment of Patient W.C.[2], including but not limited to the following:

A. Patient W.C., a 58 year old male living in a board-and-care facility, came under respondent's care and treatment in May 1996. The patient had a past medical history significant for a diagnosis of schizophrenia, anemia (as demonstrated by laboratory tests beginning in 1996) and chronic obstructive pulmonary disease (COPD), among other serious medical problems.

B. Respondent initially recommended a fecal occult blood test (FOBT), but after the patient failed to submit a stool sample, respondent let the matter pass without further action -- albeit he continued the diagnosis of anemia from visit-to-visit. Respondent's record represents that he continued to examine Patient W.C. on a regular basis through January 2009. However, respondent's records are duplicative and redundant, repeatedly indicating the same examinations and findings in a serial, unlikely and frankly non-credible fashion and, thereby, giving rise to the inference that records are simply copied from visit to visit without regard to what actually

[2] Patient names are abbreviated to protect privacy.

transpired. As a consequence of respondent's poor record keeping, it is difficult to determine what the patient's condition actually was at any given time.

C. Beginning on January 28, 2005, respondent's records note a decreased hemoglobin level, which had been periodically tested and remained stable for a number of years. On the next visit, on March 2, 2005, respondent charted a plan for GI referral for a screening colonoscopy and this is repeated at the next visit and sporadically in later records, without any conclusion or resolution of the concern.

D. Beginning in March 2007, respondent adopted an electronic format for his medical record keeping. Beginning at that time, respondent began producing a six-page record for each visit in which extensive, detailed -- and highly unlikely -- physical examinations are indicated by checked boxes. That these records are inaccurate and unreliable is supported by the unintelligible statement that "other problems in sentencing onion are inconsidered were in fact considered during this visit" -- which nonsensical statement is copied from visit to visit without correction.

E. At the May 15, 2007 visit, the patient's chief complaint is listed as anemia, however laboratory tests are listed as "pending" -- a status which respondent's records had repeated from visit to visit over the period of a year since April 2006.

F. On September 24, 2007, the patient presented with complaints of nausea and vomiting and respondent entered a diagnosis of GERD/PUD and ordered various laboratory and imaging tests, but did not perform an evaluation for possible colon cancer as the cause of the patient's continued diagnosis of anemia.

G. On March 25, 2008, the patient reported a weight loss of 8-10 lbs.; however, respondent's records fail to indicate the patient's normal weight or his weight at the March visit. Laboratory tests showed markedly decreased hemoglobin levels and respondent charted a plan for consultation for colonoscopy/endoscopy. As previously alleged, respondent's records are routinely copied from visit to visit, repeating even obvious typographical and content errors, and devoid of meaningful information about the patient's status; however, from what can be gleaned from respondent's records, the plan for colonoscopy was not followed up on. Similarly, there is

no record of a rectal exam, FOBT or other test directed to evaluate the patient for possible colon cancer.

G. On January 2, 2009 the patient presented with a weight of 133 lbs. and stated that his normal weight was 150 lbs. A laboratory test was performed on January 13 and reported on January 15, but not reviewed by respondent until January 23, at which time he recognized the patient's hemoglobin level of 6.8 required urgent hospitalization. Patient W.C. was admitted to San Leandro Hospital for evaluation, at which time a right colonic mass was diagnosed per Barium enema. Patient W.C. refused treatment and was discharged back to his board-and-care facility. On April 13, 2009, he was readmitted for weakness and a diagnosis of metastatic colon cancer was rendered. The patient again refused treatment, which was considered reasonable given his terminal diagnosis.

9. Respondent is guilty of unprofessional conduct and respondent's license is subject to disciplinary action pursuant to Sections 2234(b) and/or (c) and/or 2261 and/or 2266 of the Code in that respondent was grossly negligent and/or committed repeated negligent acts and/or failed to maintain adequate and accurate records of his care and treatment of Patient W.C., including but not limited to the following:

A. Respondent's medical records for W.C. are redundant and often identical in content, indicating that they were generated without regard to the patient's condition or what actually transpired at each visit;

B. Respondent's records indicate that examinations are repeated at each visit in such unlikely fashion as to indicate that they falsely state examinations and findings that were not in fact done or made;

C. Respondent failed to recognize and/or failed to follow up on signs and symptoms of colon cancer, including anemia, weight loss and abdominal tenderness and failed to aggressively pursue examinations and tests to rule out colon cancer, resulting in an unreasonable 2 ½ year delay in that diagnosis.

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SECOND CAUSE FOR DISCIPLINARY ACTION

(Patient T.F.)

(Gross Negligence, Repeated Negligent Acts/False & Inadequate Records)

10. Respondent's license is subject to discipline and respondent is guilty of unprofessional conduct in violation of Business and Professions Code §§ 2234, and subsections (b) and/or (c), and/or § 2261 and § 2266 in that respondent was grossly negligent and/or committed repeated negligent acts and/or failed to maintain truthful, adequate and accurate medical records in his patient care and treatment of Patient T.F., including but not limited to the following:

A. Patient T.F., a 28 year old male living in a board-and-care facility, came under respondent's care and treatment on October 28, 2003. The patient had a past medical history significant for a diagnosis of Lowe's Syndrome, with severe mental retardation, seizure disorder, and renal tubular disfunction, among other serious medical problems.

B. Respondent saw Patient T.F. approximately every 2-3 months until the patient was admitted to St. Rose Hospital for a kidney infection on June 25, 2009. However, due to the fact that respondent's records are redundant and repetitive, without any changes between multiple visits, it is difficult to determine what T.F.'s condition was at any time during the treatment. Even obvious errors, such as a reference to chronic anti-psychotic medications (which T.F. was not in fact taking), are repeated in the records for multiple visits.

C. In respondent's records, Patient T.F.'s chief complaint varies from visit to visit, and the repetitive introduction of "new" complaints raise doubts regarding whether there was a medical indication for each examination (such as the patient's incontinence secondary to severe mental retardation, which would not benefit from medical attention). Further, the fact that the chief complaint from the prior visits is not discussed or followed up on, raises doubts whether it resolved or was even accurately stated to begin with. Similarly, review of the records indicates that the physical examination is the same in all the visits and a psychiatric examination is repeated for multiple visits, although it would neither be standard practice nor medically necessary to repeat such examinations on serial visits. Beginning in June 2007, respondent

adopted an electronic format for his medical record keeping regarding T.F. Beginning at that time, respondent began producing a six-page record for each visit in which extensive, detailed -- and highly unlikely -- physical examinations are indicated by checked boxes.

D. Albeit respondent's records make reference to plans for laboratory tests and/or consultations, he did not order laboratory tests, such as a chemistry panel or urinalysis, when such tests would have been indicated by the patient's chronic renal insufficiency and other serious medical problems. Similarly, respondent either did not document or did not refer the patient for appropriate consultations with specialists in nephrology, gastroenterology, ophthalmology or dentistry, for his multiple medical problems.

11. Respondent is guilty of unprofessional conduct and respondent's license is subject to disciplinary action pursuant to Sections 2234(b) and/or (c) and/or 2261 and/or 2266 of the Code in that respondent was grossly negligent and/or committed repeated negligent acts and/or failed to maintain truthful, adequate and accurate records of his care and treatment of Patient T.F., including but not limited to the following:

A. Respondent's medical records for T.F. are redundant and often identical in content, indicating that they were generated without regard to the patient's condition or what actually transpired at each visit;

B. Respondent's records for T.F. indicate that examinations are repeated at each visit in such unlikely fashion as to indicate that they falsely state examinations and findings that were not in fact done or made;

C. Respondent's documented reason for multiple medical visits does not amount to a medical indication for the stated care and treatment;

D. Respondent failed to order appropriate laboratory tests and consultations for evaluation and follow up of Patient T.F.'s multiple medical problems.

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THIRD CAUSE FOR DISCIPLINARY ACTION

(Patient G.B., H.C., W.M., J.B. and C.C.)

(Gross Negligence, Repeated Negligent Acts/False & Inadequate Records)

12. As a separate cause for discipline and as a matter in aggravation regarding the First and Second Causes for Disciplinary Action, complainant alleges that respondent's license is subject to discipline and respondent is guilty of unprofessional conduct in violation of Business and Professions Code §§ 2234, and subsections (b) and/or (c), and/or § 2261 and § 2266 in that respondent was grossly negligent and/or committed repeated negligent acts and/or failed to maintain adequate and accurate medical records in his patient care and treatment of Patient G.B., H.C., W.M., J.B. and C.C., including but not limited to the following:

Patient G.B.

A. Patient G.B., a 53 year old male living in a board-and-care facility, came under respondent's care and treatment on July 4, 2004. The patient had a past medical history, as documented by respondent, which was significant for developmental disability, seizure disorder, hepatitis C, a positive tuberculin test and urinary incontinence.

B. Respondent's initial evaluation of the patient was inadequate in multiple respects in that respondent failed to obtain a complete history of multiple serious medical problems, including their etiology, course, the indications for treatment and the effectiveness of the patient's current treatment. Respondent continued the patient on a medication regimen which included Lamictal, 50 mg. q.p.m., Neurontin 600 mg. b.i.d., Ditropan-XL 10 mg. h.s., pyridoxine 50 mg. q.d., Depakote 500 mg. b.i.d.

C. Respondent continued to treat Patient G.B. through December 2007. Although the patient was taking multiple psychiatric medications, respondent's examinations regularly omitted mental status evaluations. Records for follow-up visits fail to set forth the effectiveness of the patient's medications. Those medications are changed from time to time, such as the addition of the anti-seizure medications Neurontin and Tegretol, without explanation for respondent's rationale. Similarly multiple tests are ordered without any documentation of the rationale. Although, from the history and diagnoses documented by respondent, the patient would have

benefited from referral for evaluation of multiple medical problems by an appropriate specialist (e.g., evaluation of the patient's Hepatitis C, his urinary incontinence and mycotic toenails) consultation orders were not written by respondent.

Patient H.C.

D. Patient H.C., a 65 year-old schizoaffective male residing in a board-and-care facility, was first seen by respondent on December 18, 2005. The patient had a past medical history, as documented by respondent, which was significant for schizoaffective disorder, chronic obstructive pulmonary disease and insomnia. His chronic medications upon respondent's assumption of care were Ambien 10 mg. q.h.s., clonazepam at night, Depakote 1500 mg., Lamictal 50 mg. q.a.m, Neurontin 600 mg. q.a.m., and 12 mg. q.h.s., Risperdal 4 mg. b.i.d., Zyprexa 10 mg. b.i.d., and multivitamin. On this first examination, respondent did not perform a complete mental evaluation of this patient diagnosed with schizoaffective disorder and on multiple anti-psychotic medications. Respondent continued H.C.'s diagnoses and previous prescription regimen, without documentation of the rationale for either the diagnosis or for the use of multiple anti-psychotic medications.

E. Respondent continued to treat Patient H.C. through November 2008. Although the patient was taking multiple psychiatric medications, respondent's examinations regularly omitted mental status evaluations and there is inadequate information in the notes, regarding the patient's response to treatment. Multiple examinations are simply copied from visit to visit, albeit these examinations were not in fact performed at each visit, thereby constituting a false record of what transpired. Respondent ordered multiple tests without a documented rationale and referrals are made, e.g. for colonoscopy, without follow-up or documentation of the results.

F. On July 29, 2008, Patient H.C. was found to have an unexplained high potassium value which can be a sign of a serious medical problem; although respondent noted the abnormal value, he did not order a follow-up laboratory test.

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Patient W.M.

G. Patient W.M., a 60 year old male living in a board-and-care facility, came under respondent's care and treatment on March 16, 2002. The patient had a past medical history, as documented by respondent, which was significant for schizoaffective disorder, COPD, GERD, dementia, history of alcoholism and hepatitis C. His medications in 2002 were Zyprexa 20 mg. h.s., clonazepam 1 mg. q.a.m., 2 mg. q.h.s., Ambien 10 mg. q.h.s., Depakote 250 mg. q.a.m., 500 mg. q.h.s., BuSpar 10 mg. t.i.d., Benadryl 25 mg. h.s. and Paxil 10 mg. h.s. Respondent elected to continue W.M.'s present medications without first performing a complete mental evaluation of the patient.

H. Respondent continued to treat W.M. through November 11, 2009. Although the patient was taking multiple psychiatric medications, respondent's examinations regularly omitted mental status evaluations and there is inadequate information in the notes, regarding the patient's response to treatment. Records of multiple examinations are simply copied from visit to visit, albeit these examinations were not in fact performed at each visit, thereby constituting a false record of what transpired.

I. Although Patient W.M. had a history of hepatitis C, respondent failed to follow up on significantly abnormal laboratory test results. On September 17, 2009, Patient W.M. was found to have an elevated AFP, which was highly significant given the patient's history of liver disease and might be indicative of liver cancer. Respondent's notes discussed a possible CT scan of the abdomen and pelvis, but he never ordered these tests or otherwise followed up on the abnormal test results.

Patient J.B.

J. Patient J.B., a 33 year-old developmentally disabled male residing in a board-and-care facility, was first seen by respondent on April 28, 2004. J.B. had a history of fecal incontinence since birth, as well as a seizure disorder (with his last seizure five years prior). The latter was being treated with Depakote and phenobarbital. When respondent took over JB's care, his medications were phenobarbital, 64.8 mg. h.s., Neurontin 200 mg. t.i.d., Seroquel 800 mg. h.s., and Depakote ER 2 gr. h.s.

K. Respondent continued to treat Patient J.B. through May 2009. Although the patient was taking multiple potent medications, respondent's records regularly omitted reference to a medical indication for the medical visit or information regarding the patient's response to the prescribed treatment. In fact, the medical indication for some visits was stated to be the patient's incontinence, which condition had existed since birth and would not have benefited from medical attention. Multiple examinations are simply copied from visit to visit, albeit these detailed multi-system evaluations were not in fact performed at each visit, thereby constituting a false record of what transpired. Abnormal laboratory values are noted at various times, but then are not followed up on by respondent.

Patient C.C.

L. Patient C.C., a 40 year-old schizophrenic male, who also suffered from hypertension, hypercholesterolemia and an anxiety disorder, resided in a board-and-care facility and was first seen by respondent on September 12, 2004. C.C.'s medications at that time were Toprol XL, 50 mg. daily, Risperdal 1 mg. b.i.d., carbamazepine 200 mg. b.i.d., and clonazepam 1 mg. b.i.d.

M. Respondent continued to treat Patient C.C. through January 2010. Although the patient was taking multiple potent medications, respondent's records regularly omitted reference to a medical indication for the medical visit or information regarding the patient's response to the prescribed treatment. Multiple examinations are simply copied from visit to visit, albeit these detailed multi-system evaluations were not in fact performed at each visit, thereby constituting a false record of what transpired. Although respondent ordered laboratory tests, e.g. on June 1, 2005, many subsequent records list the labs as "pending." Remarkably, not until three years later on July 23, 2008, are laboratory tests actually documented to have been performed and the results received.

13. Respondent is guilty of unprofessional conduct and respondent's license is subject to disciplinary action pursuant to Sections 2234(b) and/or (c) and/or 2261 and/or 2266 of the Code in that respondent was grossly negligent and/or committed repeated negligent acts and/or

failed to maintain truthful, adequate and accurate records of his care and treatment of Patient G.B, H.C., W.M., J.B. and C.C., including but not limited to the following:

A. Respondent failed to perform and/or document a complete initial evaluation;

B. Respondent's follow-up care regularly omits discussion of the patient's response to treatment, the rationale for changes in medication or documentation of a current mental status evaluation;

C. Respondent repeatedly failed to follow up on his treatment plan and/or failed to follow up on significant abnormal test results;

D. Respondent's records repeat past examinations and findings, inaccurately and/or falsely representing that the same examinations were performed at each visit;

E. Respondent failed to maintain adequate and accurate medical records regarding what actually transpired at each visit.

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 30477, issued to Ernest Lincoln Bonner, Jr., M.D.

2. If placed on probation, ordering Ernest Lincoln Bonner, Jr., M.D. to pay the Medical Board of California the costs of probation monitoring;

3. Prohibiting Ernest Lincoln Bonner, Jr., M.D. from becoming or continuing to be a supervisor of physician assistants.

4. Taking such other and further action as deemed necessary and proper.

DATED: September 5, 2012

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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